MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

63-050145

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 347 Primary Registration District No. 500 Registrar's No. 3640 STATE FILE NUMBER

FILED DEC 20 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300
Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
1	4mo		
2	22	4	
3		2	
4	2		
5	2		
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7	1		
8	2		
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10			
11			
12	410		
13			
	41		

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF — DOCUMENT

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Koch, Mo
Length of stay in 1b: 87 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Robert Koch Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. COUNTY: St Louis City
c. CITY OR TOWN: St. Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2623 Delmar
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: James Middle: (none) Last: Beard

4. DATE OF DEATH: Month: Nov. Day: 25, Year: 1963

5. SEX: Male

6. COLOR OR RACE: MaleNegro

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH: 2-10-03

9. AGE (last birthday): 60 years
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Odd Jobs

11. BIRTHPLACE (City and state or country): Franklin, Kentucky

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Wesley Beard

13b. MOTHER'S MAIDEN NAME: Laura Sometime

14. NAME OF HUSBAND OR WIFE: Ada Mae Lester Beard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of servi: No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Records Koch Hospital, Koch, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 10 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 0021 B

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I(a): Late Latent Syphilis; Situs Inversus

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8-30-63, to 11-25-63 and last saw ~~her~~ him alive on 11-24-63
Death occurred at 8:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H.A. Harris (Degree or title) MD

22b. ADDRESS: Rob't. Koch Hosp, Koch, Mo

22c. DATE SIGNED: 11-26-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Anatomical B.

23b. DATE: 11-27-63

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS: ANATOMICAL St. Louis, Mo

25. DATE RECD. BY LOCAL REG.: 11-29-63

26. REGISTRAR'S SIGNATURE: John G. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

Not embalmed. Received by
Local Quartermaster Board
Nov. 1963

Calvin J. Perkins,
Local Sec.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.